Substance Abuse and Mental Health Services Administration
SAMHSA ADVISORY
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Obsessive-Compulsive Disorder and Substance Use Disorders

Obsessive-compulsive disorder (OCD) is a mental disorder characterized by intrusive, obsessive thoughts and compulsive, repetitive behaviors that often significantly interfere with work, school, relationships, and other activities and responsibilities.[1] In fact, the World Health Organization has cited OCD as being one of the top 10 causes of disability worldwide.[2]

OCD frequently co-occurs with substance use disorders (SUDs).[3,4,5,6,7] Individuals with co-occurring OCD and SUDs may have a greater level of impairment in overall psychosocial functioning than individuals with OCD but without an SUD.[4] Individuals who have both conditions may also have an increased risk for suicidality.[4,8,9] Research indicates that some individuals with OCD may develop SUDs as a method of coping with their OCD symptoms.[4,10,11,12] When an SUD and OCD co-occur, both conditions need to be addressed because the consequences, assessment, treatment, and recovery can be more complicated for each disorder when they occur together.

Because SUDs may sometimes develop as a way of coping with OCD symptoms, substance use counselors may be in a good position to help clients with undiagnosed OCD. Counselors need to understand OCD and OCD treatments so they can:

- Recognize possible OCD symptoms.
- Screen clients for possible OCD.
- Make appropriate referrals for professional assessment, diagnosis, and evidence-based OCD treatments.
- Help clients with co-occurring OCD and SUDs attain and maintain SUD recovery by understanding (and helping clients understand) how the presence of each disorder can affect the course and treatment of the other.

The goals of this *Advisory* are to raise counselors' awareness of OCD and its relationship to SUDs and to provide an overview of screening and evidence-based treatments for OCD. The *Advisory* does not provide comprehensive how-to information on treating clients with OCD. For more information, see the Resources section.

What Is OCD?

Exhibit 1 presents the diagnostic criteria for OCD listed in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5).[1]

Some of the more common types of OCD obsessions and compulsions (i.e., symptoms) are presented in Exhibits 2 and 3; however, these lists are far from exhaustive. Some studies have found gender differences in OCD symptoms. For example, symptoms related to sex and religion tend to be more common in men, and contamination- and cleaning-related symptoms tend to be more common in women.[13,14]

Individuals with OCD often have dysfunctional beliefs (e.g., about the power of their thoughts or the necessity of perfection) and varying degrees of insight into the validity of these beliefs. For example:[1]

- Individuals with good or fair insight realize that their OCD beliefs are definitely or probably not true.
- Individuals with poor insight think that their OCD beliefs are most likely true.
- Individuals with no insight are certain that their OCD beliefs are true.

How Common Is OCD?

Lifetime prevalence estimates for OCD in the United States range from 1.6 percent[15] to 2.3 percent.[6]* The prevalence is slightly higher for adult females, although males are more likely to have OCD in childhood.[1,6,14]

* Differences in estimated prevalence may reflect differences in diagnostic methods or survey types, or other methodological issues.[3,4,6]

Exhibit 1. DSM-5 Diagnostic Criteria for OCD[1]

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder.

What Is the Relationship Between OCD and SUDs?

Estimates of the lifetime prevalence of a co-occurring SUD in individuals with OCD vary widely, from less than 10 percent[16] to almost 40 percent,[6] depending on various factors.[†] However, it has been reported that fewer than half of individuals with co-occurring OCD and SUDs seek treatment for their OCD.[5] In addition, even seasoned clinicians may misdiagnose individuals with OCD symptoms, particularly symptoms involving taboo sexual thoughts.[17] These findings suggest that rates of co-occurrence may be higher than current estimates and that OCD often goes untreated.

Although OCD and SUDs are classified as clinically distinct, both are associated with high levels of compulsive behavior.[3,18,19] However, there are important differences between the compulsive behaviors of SUDs and OCD. Individuals may experience a compulsion to drink alcohol excessively or use drugs illicitly, but they tend to continue substance use because they derive some pleasure from the behavior and may only wish to discontinue the behavior because of the problems it causes in their lives. Individuals with OCD perform compulsive behaviors in response to obsessive thoughts in an effort to relieve the distress of these thoughts or out of the unrealistic belief that something bad will happen if they do not perform the compulsive behaviors.[1]

What Is the Relationship Between OCD and Other Mental Disorders?

Studies have found that 90 percent or more of individuals with OCD meet lifetime criteria for at least one other diagnosable mental or substance use disorder.[6,20] The mental disorders with the highest rates of co-occurrence (lifetime prevalence) in people with OCD include:

- **Depression**—Estimates of lifetime co-occurrence range from 45.9 percent[5] to 68.4 percent.[14]

[†] OCD and SUD co-occurrence rates vary considerably for various reasons. For example, studies indicating a high level of co-occurring OCD and SUDs tend to draw participants from community samples. Studies that use individuals being treated for a primary diagnosis of OCD (whose OCD symptoms may be more severe) tend to show a lower level of co-occurrence of OCD and SUDs.[10,16]

Exhibit 2. Common Obsessions[21]

Type	Examples
Aggressive impulses	Images of hurting a child or parent
Contamination	Becoming contaminated by shaking hands with another person
Need for order	Intense distress when objects are disordered or asymmetric
Religious	Blasphemous thoughts, concerns about unknowingly sinning
Repeated doubts	Wondering if a door was left unlocked
Sexual imagery	Recurrent pornographic images

Exhibit 3. Common Compulsions[21]

Type	Examples
Checking	Repeatedly checking locks, alarms, appliances
Cleaning	Handwashing
Hoarding*	Saving trash or unnecessary items
Mental acts	Praying, counting, repeating words silently
Ordering	Reordering objects to achieve symmetry
Reassurance-seeking	Asking others for reassurance
Repetitive actions	Walking in and out of a doorway multiple times

*DSM-5 defines hoarding as a separate condition, distinct from OCD.[1]

- **Generalized anxiety disorder**—Estimates of lifetime co-occurrence range from 31.9 percent[5] to 34.6 percent.[14]
- **Social phobia**—Estimates of lifetime co-occurrence range from 17.3 percent[7] to 36.1 percent.[14]
- **Specific phobias**—Estimates of lifetime co-occurrence range from 15.1 percent[7] to 33.0 percent.[14]
- **Panic disorder**—Estimates of lifetime co-occurrence range from 12.8 percent[5] to 20.2 percent (panic disorder and/or agoraphobia).[14]
- **Posttraumatic stress disorder**—Estimates of lifetime co-occurrence range from 11.6 percent[5] to 19.2 percent.[14]

The high incidence of co-occurring disorders makes clear how valuable integrated treatment programs can be. Integrated treatment allows for the treatment of the whole person—including medical and medication issues, mental disorders, and SUD treatment as necessary (see Resources for more information). When integrated treatment is not available, collaboration between providers becomes even more important. For example, clients may see behavioral health practitioners more frequently than they see medical practitioners; consequently, behavioral health practitioners may become aware first of new symptoms, medication side effects, or other problems requiring medical attention.

What Information Do Substance Use Treatment Counselors Need About OCD Screening?

Substance use counselors can identify clients with possible OCD symptoms; make appropriate referrals for professional assessment, diagnosis, and evidence-based OCD treatments; and help clients with both OCD and SUDs attain and maintain SUD recovery. Exhibit 4 presents examples of the kinds of questions that might be used to elicit information on the presence of OCD symptoms.

The Anxiety and Depression Association of America offers a free online OCD screening tool on its website (see Resources). Although the screening tool does not provide a score or interpretation, the instructions suggest that individuals who complete the tool print it out and take it with them when they visit a medical or behavioral health practitioner. Responses to the screening tool questions may help inform conversations between practitioners and their clients about OCD symptoms. In addition to asking about OCD symptoms, this brief screening tool includes questions about depression and substance use.

Exhibit 4. Questions That Might Elicit Information on the Presence of Obsessions or Compulsions[1]

Obsessions—Do you have disturbing and unwanted thoughts, such as:

- Thoughts of being contaminated?
- Images of a violent attack or catastrophic accident happening to you or someone else?
- Urges to attack someone?

Compulsions—Do you feel driven to do things that you don't want to do, such as:

- Repeat a behavior (such as washing your hands over and over again)?
- Check things repeatedly (such as checking the lock on your door many times before leaving home)?
- Count or arrange items repeatedly (such as putting items in a certain order or pattern until they feel "right")?

Because OCD shares many symptoms with other mental disorders, such as anxiety disorders and major depressive disorder,[1] distinguishing between OCD and other mental disorders is a task for an experienced, licensed mental health practitioner. Any client who screens positive for OCD—or, in fact, any mental disorder—will need to be referred for an assessment by a behavioral health practitioner licensed to diagnose and treat mental disorders. The same is true for clients who are not formally screened but who exhibit symptoms indicating that they may have a mental disorder (or state that they have such symptoms). For more information about general screening for mental disorders, see Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*.[22] Substance use treatment practitioners who use screening tools for mental disorders should remember that these tools are not for diagnosis.

What Treatment Is Recommended for OCD?

Behavioral health practitioners who provide treatment for OCD may choose to quantify the severity of OCD symptoms and the related impairment before and during treatment for OCD. There are standardized rating scales for this purpose. The Yale-Brown Obsessive Compulsive Scale is a reliable tool for measuring OCD symptom severity.[23,24,25,26] The client can also be asked to estimate the time spent each day engaging in obsessive-compulsive thoughts or behaviors. It is also important to track the effect of OCD symptoms on relationships, work, self-care, and recreational activities.

The first-line psychosocial therapy recommended for OCD is cognitive–behavioral therapy (CBT), especially

OCD in Children and Adolescents

Although the average age of onset of OCD in the United States is 19.5 years, 25 percent of cases are diagnosed by age 14.[1] Studies suggest that 40 percent of individuals diagnosed with OCD in childhood or adolescence will experience remission by early adulthood, with appropriate treatment.[1,27,28] OCD in children and adolescents can be treated with CBT[29,30,31] and medication.[29,31]

OCD symptom expression tends to vary between children and adolescents. These differences seem to be related to content that is specific to an individual's stage of development. For example, children are more likely to fear that something bad will happen to themselves or family members.[29] Adolescents are more likely to have obsessions related to religion and sex.[1]

For more information, see:

The American Academy of Child and Adolescent Psychiatry's *Facts for Families Guide*
www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Obsessive-Compulsive-Disorder-In-Children-And-Adolescents-060.aspx

The International OCD Foundation's OCD in Kids website
https://kids.iocdf.org

a type of CBT called *exposure and ritual prevention* (ERP)[32,33,34] (sometimes called *exposure and response prevention*).[35,36,37,38] ERP involves exposing the client to a dreaded situation, event, or stimulus through the use of various techniques and then preventing the client from performing the compulsive behavior that would usually result upon exposure to such a situation.[21,32,34,37,39]

CBT/ERP can be an effective treatment for OCD, with or without medication.[32,40,41] It is important to note that although some studies on the effectiveness of ERP with medication have excluded individuals with co-occurring SUDs,[33,40,41,42] at least one has not.[34]

A number of studies have explored the use of mindfulness-based interventions in the treatment of OCD,[43,44,45,46,47,48] and clinical trials are in progress.[49,50] However, these are mostly very small studies, suggesting that research in this area is still in its infancy.

Clomipramine (a tricyclic antidepressant) and four selective serotonin reuptake inhibitors (SSRIs; fluoxetine, fluvoxamine, paroxetine, and sertraline) are approved by the Food and Drug Administration for the treatment of OCD.[21,35,36] However, SSRIs are now considered first-line pharmacologic treatments for the disorder. The doses of SSRIs that are required to successfully treat OCD are often higher than the doses required for other conditions. In addition, an individual with OCD may take longer to respond to these medications. For this reason, trial periods are often longer (at least 12 weeks).[51,52] Although all of the SSRIs listed above seem to be equally effective in the treatment of OCD, an individual patient may respond better to one SSRI than to another.[35]

Note: Prescribed medications can interact with drugs and alcohol—clients taking prescribed medications should be encouraged to be open about their use of substances with their care providers.

A number of studies have explored the effectiveness of using adjunctive medications to improve treatment outcomes for individuals who do not respond well to SSRI medication alone. Additional medications being investigated include antipsychotics,[52,53,54,55] *N*-acetylcysteine,[56,57] and memantine.[58,59,60]

Whether a client's behavioral health problems are being treated with medication, behavioral therapy, or both, it is important for clients and practitioners to shift the focus from primarily illness and disease to wellness and recovery. An approach focusing on wellness and recovery is strengths based and includes interventions to help clients become proactive in managing their overall health and well-being.[61] It focuses on reclaiming important aspects of life that were lost when a mental or substance use disorder began, or on discovering these aspects for the first time. The Substance Abuse and Mental Health Services Administration has identified several essential dimensions of a holistic approach to recovery and wellness (see Exhibit 5).

Exhibit 5. Dimensions of Recovery and Dimensions of Wellness[62,63,64]

Dimensions of Recovery	Dimensions of Wellness
Health	• *Physical:* Recognizing the need for physical activity, healthy foods, and sleep; managing chronic illnesses • *Emotional:* Coping effectively with life and creating satisfying relationships
Home	• *Environmental:* Occupying pleasant, safe, stimulating environments that support well-being • *Financial:* Obtaining satisfaction with current and future financial situations
Purpose	• *Intellectual:* Recognizing creative abilities and finding ways to expand knowledge and skills • *Occupational:* Obtaining personal satisfaction and enrichment from one's work or daily activity • *Spiritual:* Expanding one's sense of purpose and meaning in life
Community	• *Social:* Building a sense of connection and belonging; building a well-developed support system

ADVISORY

OCD is a chronic illness with a high rate of relapse.[21] Patients with OCD may require continued monitoring for the possible recurrence of symptoms or the development of depression and suicidal thoughts.[21] However, remission is possible. Some studies have found that remission from OCD is related to the type and severity of symptoms, the duration of the illness,[65,66] and initial response to medication.[67] One study found that some individuals with OCD were able to discontinue medication without a worsening of symptoms.[68] Like most health care, however, personalized behavioral health care that focuses not only on illness and disease, but also on wellness and recovery, may provide the healing environment most conducive to achieving positive outcomes.

Resources

Relevant publications

Treatment Improvement Protocol (TIP) 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders*
http://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

Obsessive-Compulsive Disorder: When Unwanted Thoughts Take Over
www.nimh.nih.gov/health/publications/obsessive-compulsive-disorder-when-unwanted-thoughts-take-over

Partners in Health: Mental Health, Primary Care and Substance Use Interagency Collaboration Tool Kit
www.integration.samhsa.gov/operations-administration/IBHP_Interagency_Collaboration_Tool_Kit_2013.pdf

Web resources

Anxiety and Depression Association of America (offers an online screening tool for OCD)
www.adaa.org/screening-obsessive-compulsive-disorder-ocd

Beyond OCD
www.beyondocd.org

International OCD Foundation (contains a searchable directory for OCD therapists, clinics, treatment programs, and support groups)
www.iocdf.org

National Institute of Mental Health
www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd

SAMHSA-HRSA Center for Integrated Health Solutions (jointly funded by SAMHSA and the Health Resources and Services Administration [HRSA] and run by the National Council for Behavioral Health)
www.integration.samhsa.gov

Notes

1 American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

2 World Health Organization. (2001). *Ministerial round tables: Mental health.* Geneva, Switzerland: Author.

3 Blom, R. M., Koeter, M., van den Brink, W., de Graaf, R., Ten Have, M., & Denys, D. (2011). Co-occurrence of obsessive-compulsive disorder and substance use disorder in the general population. *Addiction, 106,* 2178–2185.

4 Mancebo, M. C., Grant, J. E., Pinto, A., Eisen, J. L., & Rasmussen, S. A. (2009). Substance use disorders in an obsessive compulsive disorder clinical sample. *Journal of Anxiety Disorders, 23,* 429–435.

5 Mayerovitch, J. I., du Fort, G. G., Kakuma, R., Bland, R. C., Newman, S. C., & Pinard, G. (2003). Treatment seeking for obsessive-compulsive disorder: Role of obsessive-compulsive disorder symptoms and comorbid psychiatric diagnoses. *Comprehensive Psychiatry, 44*(2), 162–168.

6 Ruscio, A. M., Stein, D. J., Chiu, W. T., & Kessler, R. C. (2010). The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. *Molecular Psychiatry, 15,* 53–63.

7 Torres, A. R., Prince, M. J., Bebbington, P. E., Bhugra, D., Brugha, T. S., Farrell, M., et al. (2006). Obsessive-compulsive disorder: Prevalence, comorbidity, impact, and help-seeking in the British National Psychiatric Morbidity Survey of 2000. *American Journal of Psychiatry, 163*(11), 1978–1985.

8 Gentil, A. F., de Mathis, M. A., Torresan, R. C., Diniz, J. B., Alvarenga, P., Rosário, M. C., et al. (2009). Alcohol use disorders in patients with obsessive-compulsive disorder: The importance of appropriate dual diagnosis. *Drug and Alcohol Dependence, 100,* 173–177.

9 Torres, A. R., Ramos-Cerqueira, A. T. A., Ferrão, Y. A., Fontenelle, L. F., do Rosário, M. C., & Miguel, E. C. (2011). Suicidality in obsessive-compulsive disorder: Prevalence and relation to symptom dimensions and comorbid conditions. *Journal of Clinical Psychiatry, 72*(1), 17–26.

10 Cuzen, N. L., Stein, D. J., Lochner, C., & Fineberg, N. A. (2014). Comorbidity of obsessive-compulsive disorder and substance use disorder: A new heuristic. *Human Psychopharmacology: Clinical and Experimental, 29*(1), 89–93.

11 Sbrana, A., Bizzarri, J. V., Rucci, P., Gonnelli, C., Doria, M. R., Spagnolli, S., et al. (2005). The spectrum of substance use in mood and anxiety disorders. *Comprehensive Psychiatry, 46,* 6–13.

[12] Swendsen, J., Conway, K. P., Degenhardt, L., Glantz, M., Jin, R., Merikangas, K. R., et al. (2010). Mental disorders as risk factors for substance use, abuse and dependence: Results from the 10-year follow-up of the National Comorbidity Survey. *Addiction, 105,* 1117–1128.

[13] Labad, J., Menchon, J. M., Alonso, P., Segalas, C., Jimenez, S., Jaurrieta, N., et al. (2008). Gender differences in obsessive-compulsive symptom dimensions. *Depression and Anxiety, 25,* 832–838.

[14] Torresan, R. C., Ramos-Cerqueira, A. T. A., Shavitt, R. G., do Rosário, M. C., de Mathis, M. A., Miguel, E. C., & Torres, A. R. (2013). Symptom dimensions, clinical course and comorbidity in men and women with obsessive-compulsive disorder. *Psychiatry Research, 209*(2), 186–195.

[15] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 593–602.

[16] Lochner, C., Fineberg, N. A., Zohar, J., van Ameringen, M., Juven-Wetzler, A., Altamura, A. C., et al. (2014). Comorbidity in obsessive-compulsive disorder (OCD): A report from the International College of Obsessive-Compulsive Spectrum Disorders (ICOCS). *Comprehensive Psychiatry, 55,* 1513–1519.

[17] Glazier, K., Calixte, R. M., Rothschild, R., & Pinto, A. (2013). High rates of OCD symptom misidentification by mental health professionals. *Annals of Clinical Psychiatry, 25*(3), 201–209.

[18] Figee, M., Vink, M., de Geus, F., Vulink, N., Veltman, D. J., Westenberg, H., & Denys, D. (2011). Dysfunctional reward circuitry in obsessive-compulsive disorder. *Biological Psychiatry, 69,* 867–874.

[19] Meunier, D., Ersche, K. D., Craig, K. J., Fornito, A., Merlo-Pich, E., Fineberg, N. A., et al. (2012). Brain functional connectivity in stimulant drug dependence and obsessive-compulsive disorder. *NeuroImage, 59,* 1461–1468.

[20] Pinto, A., Mancebo, M. C., Eisen, J. L., Pagano, M. E., & Rasmussen, S. A. (2006). The Brown Longitudinal Obsessive Compulsive Study: Clinical features and symptoms of the sample at intake. *Journal of Clinical Psychiatry, 67*(5), 703–711.

[21] Fenske, J. N., & Schwenk, M. D. (2009). Obsessive-compulsive disorder: Diagnosis and management. *American Family Physician, 80*(3), 239–245.

[22] Substance Abuse and Mental Health Services Administration. (2005). *Substance abuse treatment for persons with co-occurring disorders.* Treatment Improvement Protocol (TIP) Series 42. HHS Publication No. (SMA) 13-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[23] Baer, L., & Blais, M. A. (Eds.). (2010). *Handbook of clinical rating scales and assessment in psychiatry and mental health.* New York, NY: Humana.

[24] Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Delgado, P., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale, II: Validity. *Archives of General Psychiatry, 46,* 1012–1016.

[25] Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., et al. (1989). The Yale-Brown Obsessive Compulsive Scale, I: Development, use, and reliability. *Archives of General Psychiatry, 46,* 1006–1011.

[26] Grabill, K., Merlo, L., Duke, D., Harford, K.-L., Keeley, M. L., Geffken, G. R., & Storch, E. A. (2008). Assessment of obsessive-compulsive disorder: A review. *Journal of Anxiety Disorders, 22,* 1–17.

[27] Bloch, M. H., Craiglow, B. G., Landeros-Weisenberger, A., Dombrowski, P. A., Panza, K. E., Peterson, B. S., & Leckman, J. F. (2009). Predictors of early adult outcomes in pediatric-onset obsessive-compulsive disorder. *Pediatrics, 124*(4), 1085–1093.

[28] Palermo, S. D., Bloch, M. H., Craiglow, B., Landeros-Weisenberger, A., Dombrowski, P. A., Panza, K., et al. (2011). Predictors of early adulthood quality of life in children with obsessive-compulsive disorder. *Social Psychiatry and Psychiatric Epidemiology, 46*(4), 291–297.

[29] American Academy of Child and Adolescent Psychiatry. (2013). *Facts for families guide: Obsessive-compulsive disorder in children and adolescents.* Retrieved July 29, 2016, from www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Obsessive-Compulsive-Disorder-In-Children-And-Adolescents-060.aspx

[30] Choate-Summers, M. L., Freeman, J. B., Garcia, A. M., Coyne, L., Przeworski, A., & Leonard, H. L. (2008). Clinical considerations when tailoring cognitive behavioral treatment for young children with obsessive compulsive disorder. *Education and Treatment of Children, 31*(3), 395–416.

[31] Wagner, A. P. (2009). *Obsessive compulsive disorder in children and teenagers* [Fact sheet]. Retrieved July 29, 2016, from https://iocdf.org/wp-content/uploads/2014/10/OCD-in-Children-and-Teenagers-Fact-Sheet.pdf

[32] Foa, E. B., Liebowitz, M. R., Kozak, M. J., Davies, S., Campeas, R., Franklin, M. E., et al. (2005). Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. *American Journal of Psychiatry, 162,* 151–161.

[33] Foa, E. B., Simpson, H. B., Liebowitz, M. R., Powers, M. B., Rosenfield, D., Cahill, S. P., et al. (2013). Six-month follow-up of a randomized controlled trial augmenting serotonin reuptake inhibitor treatment with exposure and ritual prevention for obsessive-compulsive disorder. *Journal of Clinical Psychiatry, 74*(5), 464–469.

[34] Franklin, M. E., Abramowitz, J. S., Kozak, M. J., Levitt, J. T., & Foa, E. B. (2000). Effectiveness of exposure and ritual prevention for obsessive-compulsive disorder: Randomized compared with nonrandomized samples. *Journal of Consulting and Clinical Psychology, 68*(4), 594–602.

[35] American Psychiatric Association. (2007). *Practice guideline for the treatment of patients with obsessive-compulsive disorder.* Arlington, VA: Author.

[36] American Psychiatric Association. (2013). *Guideline watch (March 2013): Practice guideline for the treatment of patients with obsessive-compulsive disorder.* Retrieved July 29, 2016, from www.psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/ocd-watch.pdf

[37] Fisher, P. L., & Wells, A. (2005). How effective are cognitive and behavioral treatments for obsessive-compulsive disorder? A clinical significance analysis. *Behaviour Research and Therapy, 43,* 1543–1558.

[38] Pittenger, C., Kelmendi, B., Bloch, M., Krystal, J. H., & Coric, V. (2005). Clinical treatment of obsessive compulsive disorder. *Psychiatry, 2*(11), 34–43.

[39] Olatunji, B. O., Rosenfield, D., Tart, C. D., Cottraux, J., Powers, M. B., & Smits, J. A. J. (2013). Behavioral versus cognitive treatment of obsessive-compulsive disorder: An examination of outcome and mediators of change. *Journal of Consulting and Clinical Psychology, 81*(3), 415–428.

[40] Simpson, H. B., Liebowitz, M. R., Foa, E. B., Kozak, M. J., Schmidt, A. B., Rowan, V., et al. (2004). Post-treatment effects of exposure therapy and clomipramine in obsessive-compulsive disorder. *Depression and Anxiety, 19,* 225–233.

[41] Tenneij, N. H., van Megen, H. J., Denys, D. A., & Westenberg, H. G. (2005). Behavior therapy augments response of patients with obsessive-compulsive disorder responding to drug treatment. *Journal of Clinical Psychiatry, 66,* 1169–1175.

[42] Maher, M., Huppert, J. D., Chen, H., Duan, N., Foa, E. B., Liebowitz, M. R., et al. (2010). Moderators and predictors of response to cognitive-behavioral therapy augmentation of pharmacotherapy in obsessive-compulsive disorder. *Psychological Medicine, 40*(12), 2013–2023.

[43] de Zoysa, P. (2013). The use of mindfulness practice in the treatment of a case of obsessive compulsive disorder in Sri Lanka. *Journal of Religion and Health, 52,* 299–306.

[44] Hertenstein, E., Rose, N., Voderholzer, U., Heidenreich, T., Nissen, C., Thiel, N., et al. (2012). Mindfulness-based cognitive therapy in obsessive-compulsive disorder—A qualitative study on patients' experiences. *BMC Psychiatry, 12,* 1–10.

[45] Patel, S. R., Carmody, J., & Simpson, H. B. (2007). Adapting mindfulness-based stress reduction for the treatment of obsessive-compulsive disorder: A case report. *Cognitive and Behavioral Practice, 14,* 375–380.

[46] Singh, N. N., Wahler, R. G., Winton, A. S. W., Adkins, A. D., & the Mindfulness Research Group. (2004). A mindfulness-based treatment of obsessive-compulsive disorder. *Clinical Case Studies, 3,* 275–287.

[47] Wahl, K., Huelle, J. O., Zurowski, B., & Kordon, A. (2013). Managing obsessive thoughts during brief exposure: An experimental study comparing mindfulness-based strategies and distraction in obsessive-compulsive disorder. *Cognitive Therapy Research, 37,* 752–761.

[48] Wilkinson-Tough, M., Bocci, L., Thorne, K., & Herlihy, J. (2010). Is mindfulness-based therapy an effective intervention for obsessive-intrusive thoughts: A case series. *Clinical Psychology and Psychotherapy, 17,* 250–268.

[49] Kwon, J. S. (2013). *Effect of mindfulness based treatment for obsessive-compulsive disorder* [Study description]. Retrieved July 29, 2016, from https://clinicaltrials.gov/show/NCT02006199

[50] Strauss, C. (2014). *A comparison to two types of group behaviour therapy for obsessive compulsive disorder: A pilot randomised controlled trial of behaviour therapy and mindfulness-based behaviour therapy for OCD* [Study description]. Retrieved July 29, 2016, from www.isrctn.com/ISRCTN52684820

[51] Bokor, G., & Anderson, P. D. (2014). Obsessive-compulsive disorder. *Journal of Pharmacy Practice, 27*(2), 116–130.

[52] Kellner, M. (2010). Drug treatment of obsessive-compulsive disorder. *Dialogues in Clinical Neuroscience, 12*(2), 187–197.

[53] Bloch, M. H., Landeros-Weisenberger, A., Kelmendi, B., Coric, V., Bracken, M. B., & Leckman, J. F. (2006). A systematic review: Antipsychotic augmentation with treatment refractory obsessive-compulsive disorder. *Molecular Psychiatry, 11*(7), 622–632. (Erratum published 2006, *Molecular Psychiatry, 11*(8), p. 795)

[54] Simpson, H. B., Foa, E. B., Liebowitz, M. R., Huppert, J. D., Cahill, S., Maher, M. J., et al. (2013). Cognitive-behavioral therapy vs risperidone for augmenting serotonin reuptake inhibitors in obsessive-compulsive disorder: A randomized clinical trial. *JAMA Psychiatry, 70*(11), 1190–1199.

[55] Storch, E. A., Goddard, A. W., Grant, J. E., De Nadai, A. S., Goodman, W. K., Mutch, P. J., et al. (2013). Double-blind, placebo-controlled, pilot trial of paliperidone augmentation in serotonin reuptake inhibitor-resistant obsessive-compulsive disorder. *Journal of Clinical Psychiatry, 74*(6), e527–e532.

[56] Afshar, H., Roohafza, H., Mohammad-Beigi, H., Haghighi, M., Jahangard, L., Shokouh, P., et al. (2012). N-acetylcysteine add-on treatment in refractory obsessive-compulsive disorder: A randomized, double-blind, placebo-controlled trial. *Journal of Clinical Psychopharmacology, 32*(6), 797–803.

[57] Lafleur, D. L., Pittenger, C., Kelmendi, B., Gardner, T., Wasylink, S., Malison, R. T., et al. (2006). N-acetylcysteine augmentation in serotonin reuptake inhibitor refractory obsessive-compulsive disorder [Letter to the editors]. *Psychopharmacology, 184,* 254–256.

[58] Ghaleiha, A., Entezari, N., Modabbernia, A., Najand, B., Askari, N., Tabrizi, M., et al. (2013). Memantine add-on in moderate to severe obsessive-compulsive disorder: Randomized double-blind placebo-controlled study. *Journal of Psychiatric Research, 47,* 175–180.

[59] Haghighi, M., Jahangard, L., Mohammad-Beigi, H., Bajoghli, H., Hafezian, H., Rahimi, A., et al. (2013). In a double-blind, randomized and placebo-controlled trial, adjuvant memantine improved symptoms in inpatients suffering from refractory obsessive-compulsive disorders (OCD). *Psychopharmacology, 228,* 633–640.

[60] Sani, G., Serra, G., Kotzalidis, G. D., Romano, S., Tamorri, S. M., Manfredi, G., et al. (2012). The role of memantine in the treatment of psychiatric disorders other than the dementias: A review of current preclinical and clinical evidence. *CNS Drugs, 26*(8), 663–690.

[61] Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal, 29*(4), 311–314.

[62] Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's wellness initiative: Information for consumers* [Brochure]. HHS Publication No. (SMA) 12-4567. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[63] Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's working definition of recovery* [Brochure]. Publication No. 12-RECDEF. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[64] Substance Abuse and Mental Health Services Administration. (2016). *What individuals in recovery need to know about wellness.* HHS Publication No. (SMA) 16-4950. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[65] Eisen, J. L., Sibrava, N. J., Boisseau, C. L., Mancebo, M. C., Stout, R. L., Pinto, A., et al. (2013). Five-year course of obsessive-compulsive disorder: Predictors of remission and relapse. *Journal of Clinical Psychiatry, 74*(3), 233–239.

[66] Jakubovski, E., Diniz, J. B., Valerio, C., Fossaluza, V., Belotto-Silva, C., Gorenstein, C., et al. (2013). Clinical predictors of long-term outcome in obsessive-compulsive disorder. *Depression and Anxiety, 30,* 763–772.

[67] Bloch, M. H., Green, C., Kichuk, S. A., Dombrowski, P. A., Wasylink, S., Billingslea, E., et al. (2013). Long-term outcome in adults with obsessive-compulsive disorder. *Depression and Anxiety, 30,* 716–722.

[68] Grant, J. E., Mancebo, M. C., Weinhandl, E., Odlaug, B. L., Eisen, J. L., & Rasmussen, S. A. (2013). Longitudinal course of pharmacotherapy in obsessive-compulsive disorder. *International Clinical Psychopharmacology, 28*(4), 200–205.

SAMHSA Advisory

This *Advisory* was written and produced under contract numbers 270-09-0307 and 270-14-0445 by the Knowledge Application Program (KAP), a Joint Venture of JBS International, Inc., and The CDM Group, Inc., for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Christina Currier and Suzanne Wise served as the Contracting Officer's Representatives, and Candi Byrne served as KAP Project Coordinator.

Electronic Access to Publication: This publication may be downloaded from SAMHSA's Publications Ordering webpage at www.store.samhsa.gov.

Recommended Citation: Substance Abuse and Mental Health Services Administration. (2016). Obsessive-Compulsive Disorder and Substance Use Disorders. *Advisory,* Volume 15, Issue 3.

Originating Office: Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

HHS Publication No. (SMA) 16-4977
Published 2016